MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13975

CERTIFICATE OF DEATH

13980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Harman Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Ellicott City
d. STREET ADDRESS: Horseshoe Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hazel — Middle: Delawder — Last:

4. DATE OF DEATH: Month: Oct. — Day: 8 — Year: 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 13 1934

9. AGE (In years last birthday): 33 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Landy Burris

14. MOTHER'S MAIDEN NAME: Evelyn Duvall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Maynard Delawder — Address: Hourseshoe Dr Ellicott City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma, Cervix & metastasis
DUE TO
(b):
DUE TO
(c):
Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse lost.
171X
INTERVAL BETWEEN ONSET AND DEATH: 18 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-26, 1965, to 10-8, 1967, that (I) (we) last saw the deceased alive on 10-5 1967, and that death occurred at 5:15 P.M., from causes and on the date stated above.

22a. SIGNATURE: Thomas F. Herbert M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10-9-67

22c. PHYSICIAN'S NAME (Type): Thomas F. Herbert, MD

22d. ADDRESS: 44 Church Rd, Ellicott City, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/11/67

23c. NAME OF CEMETERY OR CREMATORY: Meadowridge

23d. LOCATION (City or Town) (County) (State): Elkridge Howard Md.

24. FUNERAL DIRECTOR: Higinbothom Black Funeral Home — ADDRESS: Ellicott City, Md.

25a. REC'D BY REGISTRAR DATE: OCT 13 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13976 — 13981

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: HOWARD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b: Passing through
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rogers Ave. and Balto. National Pike

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 21215
d. STREET ADDRESS: 3637 Belvedere Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: Talbot — Last: Ford

4. DATE OF DEATH: Month: 10 — Day: 19 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-7-1907

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Storekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Self-employed

11. BIRTHPLACE (State or foreign country): Reisterstown, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Arthur D. Ford

14. MOTHER'S MAIDEN NAME: Lillie May Hanna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service): None

16. SOCIAL SECURITY NO.: 214-18-6637

17. INFORMANT: Mrs. Ethel A. Cowley, 120 Clarendon Ave. — Address: Pikesville 8, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line lor (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): ~~Fracture of skull at base~~ — INTERVAL BETWEEN ONSET AND DEATH: instant
8161
DUE TO (b):
Conditions, if any, which gove rise to immediate couse (o), stoting the underlying couse lost.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Multiple Injuries

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.): Drove his car into back of truck

20c. TIME OF INJURY Month, Day, Yeor Hour a.m. 1:45 p.m. 2-19 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) Ellicott City (County) Howard (State) Md

21. I certify thot I took chorge of the remoins described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion deoth resulted from: Noturol couses ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: George E. Burgtorf M.D.

EXAMINER'S NAME (Type): GEORGE E. BURGTORF M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 10-19-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct. 21, 1967

23c. NAME OF CEMETERY OR CREMATORY: Stone Chapel Cemetery

23d. LOCATION (City or Town) Pikesville (County) Baltio., (State) Md.

24. FUNERAL DIRECTOR: Frank H. Newell — ADDRESS: Pikesville 8, Md.

25a. REC'D BY REGISTRAR DATE: OCT 26 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13977 — 13982

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Folly Quarter Rd.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
d. STREET ADDRESS: Folly Quarter Rd.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Helen — Middle: Thomas — Last: Graves

4. DATE OF DEATH: Month: Oct. — Day: 20 — Year: 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 12/27/1891

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William L Thomas

14. MOTHER'S MAIDEN NAME: Maude A. Cockran

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: J. Rodney Graves — Address: Ellicott City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart dis, 4 years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Oct. 19 67, to Oct. 20 19 67 that (I) (~~we~~) last saw the deceased alive on Oct 20 19 67, and that death occurred at 6 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Osteen Thomas M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 10/23/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 10/23/67

23c. NAME OF CEMETERY OR CREMATORY: St. Johns

23d. LOCATION (City, town or county) (State): Ellicott City, Md.

24. FUNERAL DIRECTOR: John R Slack — ADDRESS: Ellicott City
Higinbothom-Slack Funeral Home Md.

25a. REC'D BY REGISTRAR — DATE: OCT 27 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #6393 10/13/67 ph

CERTIFICATE OF DEATH

13979 — 13983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Howard Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Ellicott City
   c. LENGTH OF STAY IN 1b: 11 months
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Schafer Convalescent Home

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Harford Co.
   c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): Bel Air
   d. STREET ADDRESS: 635 Riland Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Annabel — Middle: Bel — Lost: Hopkins

4. **DATE OF DEATH**: Month: October — Doy: 6, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: November 1, 1888

9. AGE (In yeors lost birthday): 79 78 yrs.
   IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Homemaker

11. BIRTHPLACE (County & Stote, or foreign country): Baltimore City, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Herbert Lincoln Webb

14. MOTHER'S MAIDEN NAME: Kate Lippincott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
    (If yes give wor or dotes of service): —

16. SOCIAL SECURITY NO.: 213-36-8101

17. **INFORMANT** — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (o): Peripheral Vascular Collapse — INTERVAL BETWEEN ONSET AND DEATH: few
    DUE TO
    Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse lost.
    (b): Arteriosclerotic Cardio-Vascular Disease — 5yrs
    DUE TO
    (c):

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this hospital) attended the deceased from 11-7, 1966, to 10-6, 1967, that (I) (we) last saw the deceased alive on 10-3 1967, and that death occurred at 3:25 M, from causes and on the date stated above.

22a. SIGNATURE: Thomas F. Herbert M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 10-6-67

22c. PHYSICIAN'S NAME (Type): Thomas F. Herbert, M.D — 22d. ADDRESS: 44 Church Rd, Elliott City, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Oct. 9, 1967 — 23c. NAME OF CEMETERY OR CREMATORY: Darlington Cemetery — 23d. LOCATION (City or Town) (County) (State): Darlington, Harford Co. Md. 21034

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014 — 25a. RECD BY REGISTRAR DATE: OCT 10 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

Joseph William Foster

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 141
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13979

CERTIFICATE OF DEATH

13984

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessup
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box 193 B

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessup
d. STREET ADDRESS: Box 193 B
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Aileen — Middle: — Last: Moore

4. DATE OF DEATH: Month: 10 — Day: 10 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☑ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 1-26-91

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MaryLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John N. Carroll

14. MOTHER'S MAIDEN NAME: Ida Henson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Repeated Thrombosis
DUE TO
(c): Generalized Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from _____, 19__, to 10-10, 1967, that (I) (we) last saw the deceased alive on 10-4 1967, and that death occurred at 2:20 P.M., from causes and on the date stated above.

22a. SIGNATURE: Odolo Pierandrei — M.D. — ATTENDING PHYS. ☑ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 10-10-67

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 10/14/67

23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

23d. LOCATION (City or Town) (County) (State): Jessup Md.

24. FUNERAL DIRECTOR — ADDRESS: George R. Snowden Rockville Md.

25a. RECD BY REGISTRAR — DATE: OCT 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Item 18a -21 film #395 MARYLAND STATE DEPARTMENT OF HEALTH
11-6-67 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G394 11/3/67 ph

13980

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13985

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessory, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medicol Examiner's Office along with form PM3. Page 5 moy be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used os a buriol-transit permit. File pages 1 and 2 with the State Department of Health prior to buriol, cremation, or removol, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Howard; MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland; b. COUNTY: Howard
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksville; c. LENGTH OE STAY IN 1b	c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town): Clarksville
d. NAME OF HOSPITAL OR INSTITUTION (If not in haspitol, give street address): Clarksville Ridge	d. STREET ADDRESS: Clarksville, Ridge; e. IS RESIDENCE ON A FARM? YES ☐ ND ☒
3. NAME OF DECEASED (Type or print): First MARTHA; Middle ANN; Lost BRIDGES SHINN	4. DATE OF DEATH: Month October; Doy 27; Year 19 67
5. SEX: Female; 6. CDLOR OR RACE: White; 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐; 8. DATE OF BIRTH: 5-12-1914; 9. AGE (In years last birthday): 53 yrs.; IF UNDER 1 YEAR Months / Doys; IE UNDER 24 HRS. Hours / Min.	
10o. USUAL DCCUPATION (Give kind of work done during mast of working life, even if retired): Doctor; 10b. KIND OE BUSINESS OR INDUSTRY: Science	11. BIRTHPLACE (Stote or foreign country): Ill.; 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Ralph Bridges	14. MOTHER'S MAIDEN NAME: Martha Ponder
15. WAS DECEASED EVER IN U.S. ARMED EORCES? (Yes, no, or unknown): No; (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.: 216-44-7131; 17. INEORMANT: 1; Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Asphyxia due to obstruction of Tracheostomy
DUE TO
(b):
DUE TD
(c):
Conditians, if any, which gove rise to immediate cause (a), stating the underlying couse lost. 9220

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIEICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PEREORMED? YES ☒ NO ☐

20o. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OE DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) Subjects tracheostomy tube was accidently obstructed			
20c. TIME DE INJURY Month, Doy, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☒	20e. PLACE DF INJURY (Home, form, factary, street, office bldg., etc.) Home	20f. (City or town) Clarksville	(County) Howard (State) Md

21. **I certify** thot I took chorge of the remoins described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, ond in my opinion deoth resulted from: Natural couses ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.
EXAMINER'S NAME (Type): Edward F. Wilson, M.D.
CHIEE MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, tawn, or county)
22. DATE SIGNED: October 27, 1967

23o. BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b. DATE THEREOF: 10-30-67	23c. NAME OF CEMETERY OR CREMATDRY: LEE Funeral Home	23d. LOCATION (City or Town): Washington	(County) (State) D.C.
24. FUNERAL DIRECTOR: Higinbotham Stack	ADDRESS: Ellicott City Md.	25a. REC'D BY REGISTRAR DATE NOV 1 1967	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13981

CERTIFICATE OF DEATH

13986

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Rural- Poplar Springs
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RFD # 3, Mt. Airy

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Rural- Poplar Springs
d. STREET ADDRESS: RFD # 3, Mt. Airy
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: Earl — Last: Thompson
4. DATE OF DEATH: Month: Oct. — Day: 3 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 10, 1941
9. AGE (In years last birthday): 26 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine operator
10b. KIND OF BUSINESS OR INDUSTRY: J.H. A.P. Lab.
11. BIRTHPLACE (County & State, or foreign country): Poplar Springs, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Leroy Thompson
14. MOTHER'S MAIDEN NAME: Irene Lugenbeel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service): Yes
16. SOCIAL SECURITY NO.: 216-36-3627
17. INFORMANT — Address: Mrs Sandra B. Thompson, Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure, Acute — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Hypertensive Cardio Vascular disease
DUE TO (c): Chronic nephritis with anemia
592 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Secondary anemia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~this hospital~~ attended the deceased from January, 1967, to October 3 1967, that (I) ~~we~~ last saw the deceased alive on October 3 1967, and that death occurred at 2:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: G Meadors MD — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Oct 3, 1967
22c. PHYSICIAN'S NAME (Type): G.F. MEADORS, M.D.
22d. ADDRESS: 810 Toll House Ave Frederick, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 6, 1967
23c. NAME OF CEMETERY OR CREMATORY: Poplar Springs Meth.
23d. LOCATION (City or Town) (County) (State): Poplar Springs, Md.

24. FUNERAL DIRECTOR — ADDRESS: Olin L. Melesworth, Damascus, Md.
25a. RECEIVED BY REGISTRAR — DATE: OCT 9 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13982

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13987

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b: ----------
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hardman's Motel - Route 40 & St. Johns Lane

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick
d. STREET ADDRESS: 13 West 12th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MEHRL — Middle F. — Last WACHTER

4. DATE OF DEATH: Month October — Day 20, — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 9-1905

9. AGE (In years last birthday): 62 ~~63~~ yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber

10b. KIND OF BUSINESS OR INDUSTRY: Own business

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Allen T. Wachter

14. MOTHER'S MAIDEN NAME: Elizabeth V. Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 217-10-9693

17. INFORMANT: Mrs. Lola R. Wachter — Address: 13 W. 12th.St. Frederick Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: 10/21/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 23-1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State): Frederick, Md. 21701

24. FUNERAL DIRECTOR: M.R.Etchison & Son
ADDRESS: Elwood T. Whitmore Frederick, Md. 21701

25a. REC'D BY REGISTRAR DATE: OCT 25 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge